

## *New York State Department of Health*

### **Attention: Trading Partners eMedNY Known Issues as of 01/29/2009**

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This document informs you of recent issues that have been reported to CSC. The document includes Important Announcements, New eMedNY Issues, Active eMedNY Issues and Recently Closed eMedNY Issues. In addition, a link is provided to see issues that have been archived. This document will be posted on [www.nyhipaadesk.com](http://www.nyhipaadesk.com) ([ISSUES of eMedNY](#)) and will be updated as issues are corrected and/or new issues are identified. Please visit this site periodically for updates. If you do not understand the technical terminologies in this document, please consult with your technical staff or email us at [nyhipaadesk@csc.com](mailto:nyhipaadesk@csc.com).

#### **Important Announcements**

##### **APG REMITTANCE (835) Correction Notice – Capital Add On Amount**

This is a correction to information that was published in Powerpoint Slides used for APG training. Training slides listed capital add-on amounts were to be denoted by CAS OA94. This was incorrect. (Reference page 129 of slides at [http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/apg\\_presentation.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_presentation.pdf)) CAS OA94 in Loop 2110 denotes charges bundled from another paid zero line and is returned on the claim line with the highest final APG weight. Capital add-on amounts are denoted by CAS CO94 as provided in Loop 2110.

##### **APG Testing Announcement:**

The Department (eMedNY) has been ready to accept test claims from hospital providers since September 8. This end-to-end test facility permits providers to submit test claims (batches of up to 50 claims) and to receive test remittance advice. Many hospitals have not taken advantage of this testing capability. We believe that this test capability is critical to a seamless implementation and urge hospitals to submit test claims as soon as possible. Testing will provide first-hand experience with the APG claiming process.

Please direct any questions you have about the eMedNY testing facility to the eMedNY Call Center at 1-800-343-9000 or <mailto:eMedNYProviderRelations@csc.com>.

#### **New eMedNY Issues**

- **Update 01/29/2009 – APG Issues:**

Please note: all APG related issues will be published in a separate list. Please visit:

[http://www.health.state.ny.us/health\\_care/medicaid/rates/apg/docs/apg\\_known\\_issues.pdf](http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_known_issues.pdf).

## Active eMedNY Issues

- Update: 02/22/2007 – 835 Reporting Denied Claims, But No CARCs:  
This occurs when the Charged Amount is zeroes, and the claim denies. The reason is adjustments cannot be reported when the Charged Amount is zeroes because the claim will not balance since the adjustment needs to be greater than \$.00.  
The problem is primarily on Secondary paper claims because there is only one field to report Charged Amount and/or Deductible. When the Deductible is submitted, eMedNY copies the Deductible Amount to the Charged Amount field. However, this is currently happening towards the back-end of the eMedNY adjudication process. Claims that fail front-end edits, such as “Client not on file”, do not get a chance to get the Charged Amount populated and result in a denial without a CAS Segment. NYSDOH has initiated a project request to correct this problem.  
Please check this notice periodically for status update.
- Update 7/20/05 – CLP02 = 2 and no CAS\*CO\*23 – PART 2:  
CLP02 is sometimes incorrectly reporting Claim Status Code of 2 (Secondary) but not reporting Prior Payer information, which is being erroneously combined with Medicaid’s CO adjustments. However, Medicaid’s CO adjustment should be reported separately in its own CAS\*CO\*45, and the Prior Payer’s write-off and/or payment should be identified with CARC 23. CSC is assessing a solution.  
Update: 01/23/2007 – The fix will not be implemented in January 2007, as previously scheduled. A new ETA will be provided in the future.  
Please check this notice periodically for status update.
- Update 08/24/2006 – CLP02 = 1 though the claim reported a previous payer – PART 3:  
In the 835 Remittance Advice, CLP02 is sometimes incorrectly reporting Claim Status Code of 1 (Processed as Primary) even though the claim reported prior payer’s adjudication information. The 835-transaction is combining the prior payer’s payment and adjustments with NYSDOH’s CO adjustments, causing problems in the provider’s Accounts Receivable. NYSDOH’s CO adjustment should be reported separately in its own CAS\*CO\*45, and the Prior Payer’s write-off and/or payment should be identified with CARC 23.  
Update: 01/23/2007 – The fix will not be implemented in January 2007, as previously scheduled. A new ETA will be provided in the future.  
Please check this notice periodically for status update.
- Update 9/23/05 – Edit 02001 – Enforcing Balancing Compliance for COB Claims:  
This Edit was activated on 09/22/2005. As a result, Coordination of Benefit (COB) claims whose total paid-amount at the claim level did not match the sum of all the lines paid-amounts were denied. The Edit was turned off on 09/23/05.  
The denied claims will not be reprocessed. It is the submitter’s responsibility to resubmit those claims. The paid-amount at the claim level must equal the sum of all the paid-amounts reported at line level; otherwise the claim will be denied.  
Update 10/11/05 - Please note that this is a necessary, imminent change. However, DOH has decided to keep the Edit turned off, until further notice, due to the number of claims that will deny if this Edit is turned on at this point. It will be turned back on in the near future to ensure claim balancing, which is mandated by the HIPAA Rule, and

to avoid inappropriate claim adjudication. We are currently incorrectly paying claims due to inaccurate amounts being reported.

Please check this notice periodically for updates, but start making your system changes now to avoid negative impact on your cash flow.

Update: 10/21/05 – The Edit mapping/crosswalks, which can be now found in the [Crosswalks](#) folder in NYHIPAADESK, are being updated. The corresponding Claim Adjustment Reason Code for Edit 02001 is 125, and the Remark Code is N4.

Update: 02/06/06 – ETA during cycle 1489, Edit 02001 (X12 Reason 125|N4) will be set to PEND for paper claims and DENY for electronic claims. Please make system changes now. On average, over 55,000 claims are failing this Edit on a cycle basis. These claims will be affected once the status of the Edit is changed.

Update: 03/09/06 – Please note that this is a necessary, imminent change. However, DOH has decided to keep the Edit turned off, until further notice, due to the number of claims that will deny if this Edit is turned on at this point.

Please check this notice periodically for updates.

- Update 10/21/05 – Virtual Private Network (VPN) Connectivity Restrictions:  
Many providers have indicated an interest in utilizing the Internet for communicating with Medicaid. CSC is investigating a solution to allow more trading partners to utilize internet-FTP submission.  
Please check this notice periodically for updates.

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### **Closed eMedNY Issues**

- ✓ [For a list of issues archived prior to NPI conversion go to http://www.emedny.org/hipaa/news/CSC\\_eMedNY\\_News/KnownIssues\\_for\\_Associations-5-2008.pdf.](http://www.emedny.org/hipaa/news/CSC_eMedNY_News/KnownIssues_for_Associations-5-2008.pdf)

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### **Issues Resolved as of 09/11/2008**

- ✓ Update 07/30/2008 – POS Devices Download Issue:  
eMedNY is currently downloading the NPI compliant application (version 2120) to the POS terminals. In order for the automatic download to occur, the devices need to be left “powered on” during non-business hours. eMedNY is experiencing significant download failures due to the unavailability of the devices at night.  
POS terminal users are asked to verify if their terminal(s) have not been updated with the new software. Verification can be accomplished by looking at the “home” screen, which displays the version number. If the terminal is displaying 2120, then it has been updated. If not, please leave it on at night so it can be updated. Please read this month’s Special Edition Medicaid Update for additional information and instructions: [http://www.health.state.ny.us/health\\_care/medicaid/program/update/main.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm)
- ✓ Update 07/30/2008 – Low Percentage of Facilities Affiliating Their Providers:  
As announced in the NPI Special Edition Medicaid Update, eMedNY requires facilities

(hospitals, clinics and other such facilities) to report the License Numbers and NPIs of the practitioners that may be identified in facilities' claims as Attending/Service providers. eMedNY will need to create a crosswalk for each facility's NPI with the License Numbers and NPIs of the practitioners, in order to process claims from the facilities after NPI implementation. To date, a very low percentage (%?) of facilities have done their reporting. This causes a concern for the near future. Please note that Practitioner Affiliation is not the same as NPI Registration. Affiliation is an additional, distinct requirement for the previously mentioned types of facilities. Please read the NPI Special Edition Medicaid Update for additional information and instructions:

[http://www.health.state.ny.us/health\\_care/medicaid/program/update/main.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm)

- ✓ Update 06/11/2008 – Medicare COB Claims containing Invalid CARC 92:  
The Medicare Part-A Fiscal Intermediary erroneously began issuing Remittance Advice containing an invalid Claim Adjustment Reason Code (CARC). The offending Code is 92 "Claim paid in full", which was end-dated October, 2003. It is not known how long it will be for the Fiscal Intermediary to resolve this issue. Therefore, NYS Medicaid will be implementing a fix to the front-end of the eMedNY processing system to allow Code 92 in for processing. However, until this fix is promoted entire transactions that contain code 92 will be rejected.  
We recommend submitters to strip any claims with CARC 92 until further notice to minimize cash flow impact. We will provide notification once eMedNY is able to accommodate the invalid code.  
ePACES users may submit claims with the invalid code now as an alternative to holding the claims.  
Update: 07/30/2008 – A fix has been implemented to temporarily accept CARC 92 as valid. Submitters are asked to resubmit any outstanding claims.

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### • Issues Resolved as of 10/09/2008

- ✓ Update 09/11/2008 – 00103 – Adjust/Void Fields are incomplete for 837I:  
The eMedNY system has experienced a problem in processing electronic institutional (837 I) format adjustments/voids as a result of changes promoted as part of the NPI implementation. The adjustments/voids are being accepted into the system for processing but the original claim transaction control number (TCN) is being dropped resulting in a proprietary edit message of 00103 – Adjust/Void Fields are incomplete (X12 Reason 129|N59).  
The problem has been identified and the resolution was promoted the evening of September 10, 2008. Adjustment/Void claims submitted between September 1 and September 10 should be resubmitted.
- ✓ Update 09/11/2008 – Rejecting Ambulatory Claims Due to A7|96:  
Some Fee-for-Service claims are being erroneously rejected before being passed to the adjudication system. The rejected claims are reported in the Unsolicited Claim Status File (U277) with the X12 error code A7|96 – ETIN invalid or not associated with the Billing Provider. The issue has been identified and the resolution will be implemented Sept. 12, 2008. Please resubmit any affected claims.

- ✓ Update 09/11/2008 – Incorrect Submissions of Affiliated Providers’ Start Dates:  
DOH is currently analyzing the Facility Affiliations that have been submitted and is finding anomalies in the physician’s start dates that are being reported. Many submitters are reporting 01/01/2008 or today’s date as the start.  
The effective start date should be the date the practitioner first became affiliated with the facility. For the initial load period, you may use a default date of 1/1/2000 for practitioners that were affiliated with the facility prior to 1/1/2006. For practitioners whose affiliation began after 1/1/2006, the actual affiliation effective start date should be used. After the initial load period, the actual affiliation effective start and inactive dates should be used.  
The edit is Date-of-Service sensitive, which based on the erroneous reporting may create denials for any claims submitted with services before the reported start date.
- ✓ Update 09/11/2008 – Incorrect Record Length for 835 & 820 Supplemental Files:  
Last week (Sept. 8<sup>th</sup> - Cycle 1620), the Supplemental files were created with a record-length of 549, instead of the expected 600 bytes.  
The problem has been identified and corrected. The Supplemental files starting next week (Cycle 1621) will be 600 bytes. Please note last week’s files will not be recreated.
- ✓ Update 05/20/2008 – Edit 01357 - PROVIDER ID AND SERVICE ID IDENTICAL:  
This Edit was implemented on April 24, 2008 and has caused some claims to be denied. To allow our trading partners more time to code for this requirement, this Edit will be turned off temporarily. Please resubmit any affected claims.  
Edit 01357 - (X12 Reason 16|N291) verifies the Billing Provider and the Service/Attending Providers are different. When they are identical, the claim is denied. Until eMedNY is converted to use NPI, the Service/Attending Provider’s license number may be used in the Service/Attending Provider loop to bypass the Edit. For Fee for Service claims, when the Billing Provider is the same as the Service Provider it is not necessary to send the Service Provider loop.  
Update: 01/23/2007 – This Edit is now active. Electronic claims with identical Provider Identifier at the Billing and Service/Attending Provider levels will be denied.

### **Issues Resolved as of 11/12/2008**

- ✓ Update 10/10/2008 – ePACES Dropping the Medicare Covered Part A Days:  
ePACES was dropping the Medicare Covered Part A Days entry, which was causing a variety of denials depending on specific claim characteristics. ePACES was also dropping the discharge date on some claims. These issues were fixed on October 1, 2008.
- ✓ Update 10/10/2008 – Remittance Advice Creation and Auto-enrolled Providers:  
Some trading partners have inquired about some unrecognized MMIS IDs in their Remittance Advice. This happens when the claim is submitted with NPI only. As per the announcement on page 3 of the NPI Special Edition Medicaid Update, NYSDOH created new internal MMIS IDs in order to have a one-to-one relationship with the registered NPIs. The new IDs were created for the following 2 scenarios; 1) It was necessary to create new MMIS IDs when the provider registered multiple NPIs with a single MMIS ID [This is referred to as AUTO-ENROLL]; 2) Similarly, when a provider

registered a single NPI with multiple MMIS IDs, the existing MMIS IDs were all merged into a single, new MMIS ID which crosswalks to the NPI [This is referred to as COLLAPSE].

One check and Remittance Advice is produced to reflect all payments from claims processed for the NPI/ETIN combination

While providers get ready to submit NPI-only, claims submitted with both an MMIS ID and NPI are processed based on the submitted MMIS ID and are returned in the Remittance Advice for the MMIS/ETIN combination.

✓ Update 10/10/2008 – eMedNY Deactivating Some ePACES User Accounts Due to Improper Use.

Please note: Automated scripting of the ePACES online access and entry process to eMedNY is forbidden. ePACES provides individuals the ability to create and submit transactions to eMedNY over the Internet using their browser. Collecting multiple transactions created in ePACES, and submitting these as batches is also supported. However, automated programmatic scripting of the ePACES online access and entry process to eMedNY is expressly forbidden, and will result in your user ID being revoked.

Scripting is a process of storing transactions in a computer file and programming the computer to enter them in rapid succession expecting online responses. This can create serious performance problems in ePACES and unnecessarily inconvenience other users of the product.

Another practice that is not permitted is the sharing of User IDs with multiple users to enter information into ePACES at the same time. Users that share their log-on information risk deactivation in ePACES.

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## Issues Resolved as of 01/19/2009

✓ Update 11/12/2008 – Attention ePACES Users and ePACES Administrators:

The ePACES application has experienced intermittent performance issues lately. The problems are related to some users that share their log-on information with other users and utilize the system simultaneously, which causes processing conflicts in the system. This problem can be resolved by you (the user) by contacting the ePACES Administrators at your facility and obtaining your own user id.

This issue has brought to light a compliance problem. To resolve this, the [Medicaid Confidentiality Regulations](#) agreement that users click before logging on to ePACES has been updated with the following message:

*“Warning: As per the Health Insurance Portability and Accountability Act (HIPAA), CSC or the on-site ePACES Administrator is required to assign unique user ids and passwords for identifying and tracking user’s identity [Ref: § 164.312(a)(2)(i)]. Users that share their ePACES user id and password are in violation of the HIPAA Security Regulation. If this practice is detected, the user’s access will be revoked and other sanctions may apply.”*

✓ Update 11/12/2008 – Supplemental Files Not Showing Real Source of Problem:

This issue impacts those claim submitters that are not sending their NPIs.

Many calls have been received due to some edits not showing in the production 835 Supplemental files. As documented in the [835 Supplemental CG](#), there is only room for 2 edits for claims with a PEND status. When a claim fails an edit like 00162

(Recipient Ineligible on Service Date), the claim pends and is reported in the Supplemental file. eMedNY tries to show the submitters all the reason/edits the claim may have problems with, including edits that are set to pay but may be set to deny in the near future. Showing pay edits is intended to allow submitters time to prepare. For example, the NPI edits are currently set to pay in order to allow providers to transition to NPI compliance. However, these edits, such as 02023 (Attending Provider NPI Missing), are filling the 2 spots allowed for PEND edits. To mitigate this problem, submitters are asked to submit their NPIs. As long as the NPI is present in the claim, which at this point could be in addition to the legacy IDs, the NPI edits will not be reported.

Submitting the NPI as required resolves the issue.

✓ Update 11/12/2008 – Missing Remittances / Claims in PTE:

Due to a set up error, some claims have not been reported in the Remittance Advice produced in the Provider Testing Environment (PTE). The reason was the set up of some edits, such as edit 00162 (Recipient Ineligible on Service Date), which are normally set to PEND. These edits will be set to deny going forward to ensure providers get information about their submitted claims as soon as possible. As documented in the [PTE User's Guide](#), no claims shall pend.

Submitters are asked to resubmit any claims missing from their test remittance.